C O N F I D E N T I A L

New Jersey Department of Health and Senior Services
Division of AIDS Prevention and Control
HIV Home Care Program

APPLICATION FOR ELIGIBILITY

Please PRINT clearly. Answer all questions. See instructions for specific items.

☐ **INITIAL APPLICATION** ☐ **RENEWAL APPLICATION** **CLIENT ID #** _____

SECTION I - APPLICANT INFORMATION

1. Name of Applicant (Last) (First) (MI)	2. Sex (M/F)	3. Birth Date ____ / ____ / ____
4. Street Address	5. Social Security Number	
6. City State Zip Code	7. County	

8. How long have you lived at this address?	9. Is this your principal place of residence?	10. Telephone Number (Incl. Area Code)
_____ Years _____ Months	☐ Yes ☐ No	( )

11. Have you been tested positive for HIV?	12. Have you been diagnosed with AIDS?	13. Date of Application
☐ Yes ☐ No If Yes, what is the date of the test? (Use 99/99 if month or year is unknown) _____ / _____ Month / Year	☐ Yes ☐ No If Yes, what is the date of the test? (Use 99/99 if month or year is unknown) _____ / _____ Month / Year	_____ / _____ / _____ Month / Day / Year

SECTION II - CURRENT INSURANCE COVERAGES/BENEFITS

14. Have you applied for, or are you enrolled in, Supplemental Security Income (SSI) benefits?
☐ Yes ☐ No
If Yes, please check the status of your enrollment:

Status:		
☐ SSI Application in Process	Date Sent:	____ / ____ / ____
☐ SSI Approved	Date Enrolled:	____ / ____ / ____
☐ SSI Denied	Date Denied:	____ / ____ / ____
☐ Appealing for SSI	Date Appealed:	____ / ____ / ____
☐ Reapplying for SSI	Date Reapplied:	____ / ____ / ____

Reason Denied: _____

_____

15. Have you applied for, or are you enrolled in, Social Security Disability (SSD) benefits?
☐ Yes ☐ No
If Yes, please check the status of your enrollment:

Status:		
☐ SSI Application in Process	Date Sent:	____ / ____ / ____
☐ SSI Approved	Date Enrolled:	____ / ____ / ____
☐ SSI Denied	Date Denied:	____ / ____ / ____
☐ Appealing for SSI	Date Appealed:	____ / ____ / ____
☐ Reapplying for SSI	Date Reapplied:	____ / ____ / ____

Reason Denied: _____

_____

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16. Have you applied for, or are you enrolled in, the AIDS Community Care Alternatives Program (ACCAP)?

☐ Yes ☐ No

a. If Yes, please check the status of your enrollment:

Status: ☐ Application in Process Date Sent: ____ / ____ / ____

☐ ACCAP Approved Date Enrolled: ____ / ____ / ____

☐ ACCAP Denied Date Denied: ____ / ____ / ____

If denied, please check the reason denied:

☐ Not Medically Eligible

☐ Not Financially Eligible

☐ Not Medically/Financially Eligible

☐ Not Eligible for ACCAP

☐ Other (Specify): _____

a. If Yes, ID Number: _____

a. If Yes, will the HIV Home Care Program be supplementing ACCAP?

☐ Yes ☐ No

17. Have you applied for, or are you enrolled in, Jersey Care?

☐ Yes ☐ No

If Yes, please check the status of your enrollment:

Status: ☐ Application in Process Date Sent: ____ / ____ / ____

☐ Jersey Care Approved Date Enrolled: ____ / ____ / ____

☐ Jersey Care Denied Date Denied: ____ / ____ / ____

18. Do you have State Medicaid?

☐ Yes ☐ No

If Yes, please provide the following information:

ID Number: _____

Name of Program: _____

Effective Date: ____ / ____ / ____

19. Do you have Medicare A (Hospital Insurance)?

☐ Yes ☐ No

If Yes, please provide the following information:

ID Number: _____

Name of Program: _____

Effective Date: ____ / ____ / ____

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20. Do you have Medicare B (Medical Insurance)?

☐ Yes ☐ No

If Yes, please provide the following information:

ID Number: _____

Name of Program: _____

Effective Date: _____ / _____ / _____

21. Have you applied for, or are you enrolled in, other health insurance coverage?

☐ Yes ☐ No

If Yes, please provide the following information:

Date Application Sent: _____ / _____ / _____

Date of Enrollment: _____ / _____ / _____

ID Number: _____

Name of Company, Employer, or Plan: _____

_____

Address: _____

_____

Type of Plan: ☐ Major Medical

☐ Supplement to Medicare

☐ Other (Specify): _____

SECTION III - HOUSEHOLD/INCOME INFORMATION

22. Number of persons living in household:	23. Gross Monthly Income for Household from ALL Sources	24. Specify the proof of income you are providing with this application:
_____	$ _____	

25. List Household Members

Name	Relationship

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SECTION IV - CERTIFICATION AND AUTHORIZATION

A. I understand that I must be diagnosed as having AIDS or HIV infection and that the Program covers adults, adolescents and children. I authorize the release of medical records necessary to determine my eligibility.

B. I will notify the Program immediately if my/our income rises above allowable limits, if I move from New Jersey or if I become eligible for reimbursement under other health insurance/payment mechanisms, including either institutional or community based Medicaid services.

C. I authorize the release of information necessary to determine my eligibility from the records in possession of the Social Security Administration, the Internal Revenue Service, the New Jersey Division of Taxation, employers, banks and others as the need arises.

D. I understand that I may be visited by representatives of the Program in order to determine my/our satisfaction with the services being provided for use in Program evaluation and planning.

E. I certify that the information provided in this application is true and correct to the best of my knowledge.

F. I understand that the Program is entitled to repayment for incorrectly provided benefits. I further understand that I will be held liable for the costs of any benefits which are determined to have been incorrectly provided based on fraudulent, incorrect, or incomplete information provided in this application.

G. I further understand that home care services are based upon availability of funds.

Signature (or Mark) of Applicant	Date
Name of Witness (Print)	
Signature of Witness	Date
Name of Preparer, if Other Than Applicant (Print)	
Signature of Preparer	Date
Name of Person to Contact if Questions Arise	Telephone Number

IMPORTANT:
Detach and retain Instruction page. It contains important information regarding your Rights of Appeal should you be determined ineligible for participation in this program.